DCH/LNR-057 (12/04)

Michigan Department of Community Health
Board of Nursing
P.O. Box 30193
Lansing, Michigan 48909
(517) 335-0918
www.michigan.gov/healthlicense

NURSE SPECIALTY RECERTIFICATION INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Nursing. Questions regarding your application can be directed to the Michigan Board of Nursing at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

GENERAL INSTRUCTIONS FOR RELICENSURE

1. Type or print legibly on all forms and send original application, with the proper fee, to the Board of Nursing. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

2. You must submit your application for recertification with the appropriate fee.

3. Your Michigan RN license must be active prior to obtaining Nurse Specialty Recertification.

4. The appropriate specialty certification form must be submitted to the appropriate certifying agency to be completed and returned directly to the Michigan Board of Nursing.

5. You must submit proof that you have met the following continuing education requirements for your nurse specialty:

Nurse Anesthetist:	National Recertification from the Council on Recertification of Nurse Anesthetists obtained in the 2-year period preceding the date of application.
Nurse Midwife:	In the 2-year period preceding the date of application, you must provide proof of either: 1) meeting the Continuing Competency Assessment requirements of the ACNM if you were initially certified before January 1, 1996; or 2) continued certification or recertification from the ACNM Certification Council if you were initially certified after January 1, 1996; or 3) completion of 20 hours of continuing education in midwifery.
Nurse Practitioner:	National Recertification or proof of continued certification from either the ANCC, The National Certification Board of Pediatric Nurse Practitioners and Nurses or the NCC **OR** 40 hours of continuing education in the nursing specialty field obtained in the 2-year period preceding the date of application.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes before the exam date, notify the Board of Nursing in writing. Include your former name, address, social security number, and whether or not you are a candidate for the nursing examination with the new name and/or address. Telephone calls are NOT accepted for these changes. Name and address changes can be faxed to (517) 373-2179.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Nursing in writing to request a refund.

3. CONTINUING EDUCATION: This license has a continuing education requirement for renewal. Please check our website at www.michigan.gov/healthlicense for more information on the specific requirements.

THE NURSE SPECIALTY CERTIFICATION WILL EXPIRE ON THE SAME DAY AS YOUR RN LICENSE. YOUR NURSE SPECIALTY CERTIFICATION CANNOT BE RENEWED UNTIL YOUR RN LICENSE IS RENEWED. HOWEVER, YOU CAN SUBMIT BOTH FOR RENEWAL AT THE SAME TIME.

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APPLICATION FOR RECERTIFICATION OF A NURSE SPECIALTY

Authority: Public Act 368 of 1978, as amended
If this form is not completed, certification will not be issued.

Type or Print Only

Board Use Only
License Number
Date of Licensure

I AM APPLYING FOR THE FOLLOWING RECERTIFICATION:

Note: A separate application and fee must be filed for each recertification desired

- ❒ Nurse Practitioner
- ❒ Nurse Midwife
- ❒ Nurse Anesthetist

FEES: If your R.N. License Expires:

in 13-24 Months	the Fee is	$72.00	71-4704-025356
in 5-12 Months	the Fee is	$58.00	71-4704-015356
in 0-4 Months	the Fee is	$72.00	71-4704-025356

*If your current RN license expires within 120 days, you must pay the larger fee and your certification will be issued with your renewed, 2 year license.

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Daytime Phone Number with Area Code
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		
Has your Michigan nursing specialty license been lapsed more than three years? ❒ Yes ❒ No	Michigan Permanent I.D. Number and Expiration Date	

CERTIFICATION

I certify that the above statements about my qualifications for a Michigan nurse specialty certification are true.

Signature of Applicant	Date

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NURSE PRACTITIONER SPECIALTY CERTIFICATION

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, certification will not be issued.

SECTION I - APPLICANT INFORMATION

INSTRUCTIONS: Applicant should complete Section I. Type or print your name exactly as it appears on your **Registered** Nurse application. Send this form to the appropriate certifying agency for completion of Section II. **This certification must be submitted directly to the Michigan Board of Nursing by the appropriate certifying agency.**

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan RN Permanent ID Number and Expiration Date:
Street Address		
City	State	ZIP Code
Signature		Date

Indicate Agency of National Certification

☐ **AMERICAN NURSES CREDENTIALING CENTER**

- ☐ Acute Care Nurse Practitioner
- ☐ Adult Nurse Practitioner
- ☐ Family Nurse Practitioner
- ☐ School Nurse Practitioner
- ☐ Gerontological Nurse Practitioner
- ☐ Pediatric Nurse Practitioner
- ☐ Clinical Specialist in Home Health Nursing
- ☐ Clinical Specialist in Medical/Surgical Nursing
- ☐ Clinical Specialist in Adult Psychiatric & Mental Health Nursing
- ☐ Clinical Specialist in Child & Adolescent Psychiatric & Mental Health Nursing
- ☐ Clinical Specialist in Community Health Nursing
- ☐ Clinical Specialist in Gerontological Nursing

☐ **ONCOLOGY NURSING CERTIFICATION CORPORATION**

☐ **NATIONAL CERTIFICATION CORP. FOR THE OBSTETRIC, GYNECOLOGIC AND NEONATAL NURSING SPECIALTIES**

- ☐ Neonatal Nurse Practitioner
- ☐ OB/GYN Nurse Practitioner/Women's Health Care Nurse Practitioner

☐ **NATIONAL CERTIFICATION BOARD OF PEDIATRIC NURSE PRACTITIONERS AND NURSES**

☐ **AMERICAN ACADEMY OF NURSE PRACTITIONERS FOR ADULT & FAMILY NURSE PRACTITIONERS**

SECTION II - CERTIFICATION OF LICENSURE

CERTIFYING AGENCY INSTRUCTIONS: Please complete the following information. Return this certification directly to the Michigan Board of Nursing at the address above.

This is to certify that the person identified above has met the requirements for certification or recertification by the:

_____
(Name of Certifying Agency)

as a _____

_____ _____ _____
(Date of Certification) (Certification Number) (Expiration Date)

_____ _____
Authorized Signature of Certifying Agency Date

(SEAL)

_____
Print or Type Name

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

DCH/LNR-052 (02/05)

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NURSE MIDWIFE SPECIALTY CERTIFICATION

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, certification will not be issued.

INSTRUCTIONS: Applicant complete Section I. Type or print your name exactly as it appears on your Registered Nurse license. Send this form to the designated certifying agency for completion of Section II. **This certification must be submitted directly to the Michigan Board of Nursing by the designated certifying agency.**

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	Michigan RN Permanent ID Number and Expiration Date:

Street Address

City	State	ZIP Code

Signature of Applicant	Date

SECTION II - CERTIFICATION OF LICENSURE

CERTIFYING AGENCY INSTRUCTIONS: Please complete the following information. Return this certification directly to the Michigan Board of Nursing at the address above.

This is to certify that:

☐ **the person identified above has met the requirements for certification or recertificaton by the ACNM Certification Council (ACC)**

OR

☐ **the person identified above has met the Continuing Competency Assessment requirements of the ACNM.**

American College of Nurse-Midwives Certification Council

Date completed Continuing Competency Assessment Requirements _____

Date of Certification: _____

Certification Number: _____

Expiration Date : _____

_____ _____
Authorized Signature - ACNM Certification Council Date

_____
Print or Type name

(S E A L)

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

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NURSE ANESTHETIST SPECIALTY CERTIFICATION

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, certification will not be issued.

INSTRUCTIONS: Applicant complete Section I. Type or print your name exactly as it appears on your Registered Nurse license. Send this form to the designated certifying agency for completion of Section II. **This certification must be submitted directly to the Michigan Board of Nursing by the designated certifying agency.**

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	Michigan R.N. Permanent I.D. Number and Expiration Date

Street Address

City	State	ZIP Code

Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)

Signature of Applicant	Date

SECTION II - CERTIFICATION OF LICENSURE

CERTIFYING AGENCY INSTRUCTIONS: Please complete the following information. Return this certification directly to the Michigan Board of Nursing at the address above.

This is to certify that the person identified above has met the requirements for certification or recertification by the :

Council on Certification or Council on Recertification of Nurse Anesthetists

Date of Initial Certification: _____

Date of Recertification: _____

Recertification Number : _____

Expiration Date: _____

_____ _____
Authorized Signature of Certifying Agency Date

_____
Print or Type Name

(S E A L)

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